DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted per phone. LHFS III 4/23/09

PRINTED: 04/06/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295082	A. BUILDING _____ B. WING _____	03/26/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN GARDNERVILLE HEALTH & REHAB CTR	1573 MATHIAS PKWY GARDNERVILLE, NV 89410

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare recertification survey conducted at your facility on 3/23/09 through 3/26/09. The census was 38 residents. The sample size was 10 residents. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	F 000	DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW.	
F 222 SS=B	483.13(a) CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to ensure that consents for psychotropic medications were obtained in accordance with facility policy for 4 of 10 residents (#5, #6, #7, #9). Findings include: Review of the facility's policy titled "Psychotropic Medications" revealed that psychotropic medications included antipsychotic, antidepressant, antianxiety and	F 222	**F 222 –CHEMICAL RESTRAINTS** What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident # 5 now has a consent on her chart. Resident #6 now has a consent on her chart. Resident # 7 now has a consent on his chart. Resident # 9 no longer resides in the facility. How you will identify other residents having the potential to be affected by the same deficient practice. RECEIVED APR 20 2009 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Executive Director 4/20/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 222	Continued From page 1 sedative/hypnotics. The policy included informed consent forms for each psychotropic medication category. The consent forms outlined the medication, the risks and ongoing evaluation for treatment and included a space for the resident/resident's authorized representative signature for acknowledgement and consent for treatment. On 3/23/09, the interim Director of Nurses was interviewed and confirmed that it was the facility's policy to obtain consents for psychotropic medications, including antidepressants, antianxiety medications, and hypnotics. Resident #6 was admitted to the facility on 7/27/07, with diagnoses including insomnia, depression and anxiety. The resident's medications included Ambien, Xanax and Cymbalta. Record review failed to reveal evidence of consents for the Ambien and Cymbalta. On 3/23/09 at approximately 1:00 PM, the facility's pharmacy consultant confirmed that the consents were missing in Resident #6's record. Resident #7 was admitted to the facility on 6/18/08 with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease, hypertension, depression, and dysphagia. A review of Resident #7's record revealed an order for Zoloft 50 milligrams one and one-half tablets daily. Review of the consent forms failed to reveal evidence of a consent for the Zoloft. The interim Director of Nurses was unable to locate a consent form for the Zoloft for Resident #7.	F 222	An audit has been conducted to determine if any consents for psychoactive medications are missing from the residents charts. Upon completion of the audit any missing consents were obtained. What measures have been put in place or what systematic changes you will make to ensure that the deficient practice does not recur. All Residents with new orders for chemical restraints and all new residents' charts will be reviewed within the first 24 to 48 hours of admission for the need for consents. Licensed nurses have been in-serviced on the protocol for psychoactive medications and consents for use. How the facility will monitor its corrective actions to ensure that deficient practice is being corrected and will not recur, i.e. what program will be put in place to	

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F 222	Continued From page 2 Resident #5 was admitted to the facility on 7/17/08 with diagnoses of chronic airway obstruction, hypertension, obesity, diabetes, decubitus ulcer, and chronic pain syndrome. Her psychotropic medications included Citalopram and Temazepam. A review of the resident's record revealed a consent for the Citalopram, but not one for the Temazepam. On 3/24/09 at 10:45 AM the interim Director of Nurses stated, "We should have had a consent for Temazepam. Our policy is to have consents for all antidepressants, antipsychotics, antianxiety, and hypnotics." Resident #9 was admitted on 10/29/08 with diagnoses of dementia, diabetes, depressive disorder, and esophogeal reflux. Her psychotropic medications included Ambien and Wellbutrin. Review of the resident's record failed to reveal consents for the psychotropic medications. On 3/25/09 at 10:00 AM the interim Director of Nurses stated, "The consents should have been in the chart."	F 222	monitor the continued effectiveness of the systemic change. The facility will monitor the effectiveness through the audits conducted by Medical Records that are discussed at the Daily (Mon-Friday) Department Managers Meeting and reviewed by the Continuous Quality Assurance Committee at their Monthly Meeting. Compliance Date 4-30-09	
F 249 SS=B	483.15(f)(2) ACTIVITY DIRECTOR QUALIFICATIONS The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1	F 249	**F- 249 ACTIVITY DIRECTOR QUALIFICATIONS.** What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. The current Activities Director is being enrolled in a qualified program to become a Certified Activity Professional. (National Certification Council for Activity Professionals) How you will identify other residents having the potential to be	

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F 249	Continued From page 3 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Activity Director met the qualification criteria for the position. Findings include: A review of the personnel record of the Activities Director revealed that she had transferred from a Carson City facility where she had served as an Activity Coordinator since July of 2008. The employee had no previous background working in activity or recreational positions. The employee was not enrolled in a certification program. An interview with Administrator revealed the facility was working on getting the employee enrolled in a correspondence certification program, but had not done so at the time of the survey.	F 249	affected by the same deficient practice. There were no negative outcomes to any resident because of this deficient practice. What measures have been put in place or what systematic changes you will make to ensure that the deficient practice does not recur. The Executive Director will review annually the qualification of all Employees of the facility to ensure they meet the current State, Federal and Company qualification to provide Services to the Residents of the Facility. How the facility will monitor its corrective actions to ensure that deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change. The facility will monitor the effectiveness through the annual audits conducted for the Executive Director by Department Managers	
F 312 SS=B	483.25(a)(3) ACTIVITIES OF DAILY LIVING A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		

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F 312	Continued From page 4 Based on record review and interviews, the facility failed to have documented evidence that residents were provided the necessary services to maintain personal hygiene for 4 of 10 residents (#4, #6, #7, #9). Findings include: Resident #9 was admitted on 10/29/09 with diagnoses of dementia, depressive disorder, diabetes, and esophogeal reflux. The resident's activities of daily living (ADL) record for March revealed that the resident did not receive a bath for thirteen days, from 2/28/09 to 3/12/09. The record indicated that on 3/6/09 and 3/10/09 the resident refused to be bathed. There were lines through the other days, which, according to the certified nurses aide (CNA) supervisor, meant that baths were not given. On 11/25/09 at 10:45 AM, a licensed practical nurse (LPN) was interviewed regarding the protocol of bathing refusals. The LPN stated "The CNA's come to me and I document the refusal in the nurses notes. We try to explain to the resident that we're on a bathing schedule on Tuesdays and Fridays. The CNA did let me know that Resident #9 refused on the 10th. It's supposed to be care-planned." A review of Resident #9's record failed to reveal a care plan with regard to bathing; the last nurses note entry was on 2/25/09. Resident #4 was admitted to the facility on 11/8/07 with diagnoses including post-cerebral vascular accident, dysphagia, failure to thrive, hypertension and hemiplegia. The resident was fed by G-tube, had a Foley catheter, and required total assistance with all ADLs.	F 312	and reviewed by the Continuous Quality Assurance Committee at their Monthly Meeting. Compliance Date 4-30-09 **F-312 ACTIVITIES OF DAILY LIVING** What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident # 4- Resident is scheduled for showers on Tuesday and Fridays in the PM. Resident # 6- Resident is scheduled for showers Tuesday and Fridays on the day shift. Resident # 7 – Resident is scheduled on Wednesdays and Saturdays. Resident # 9 – This individual no longer resides in the facility. How you will identify other residents having the potential to be	

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F 312	Continued From page 5 A review of the ADL sheets for the month of March 2009 failed to reveal evidence of bathing from 3/7/09 to 3/19/09. None of the dates was marked as refused or was any other notation recorded. A review of the skin risk assessment indicated Resident #4 was at high risk for skin breakdown due to her disabilities. Resident #7 was admitted to the facility on 6/18/08 with diagnoses including Alzheimer's disease, chronic obstructive pulmonary disease, hypertension, depression, and dysphagia. A review of the ADL sheets for March of 2009 failed to reveal evidence of bathing from 3/1/09 to 3/10/09. None of the dates revealed a refusal or any other notation as to why the resident was not bathed. Resident #6 was admitted to the facility on 7/27/07, with diagnoses including colostomy, difficulty walking, rheumatoid arthritis, debility, depression and anxiety. The resident had colostomy care and required assistance with hygiene and bathing. A review of the ADL sheets for the month of March 2009 failed to reveal evidence of bathing from 3/4/09 to 3/16/09. None of the dates was marked as refused; dash marks were in the bathing section and no other notation was recorded. A review of the skin risk assessment indicated Resident #6 was at risk for skin breakdown due to her disabilities. On 3/24/09 at approximately 11:20 AM, the CNA supervisor was interviewed and confirmed that the coding of a dash (-) on the nurse's aide record of bathing indicated that bathing was not	F 312	affected by the same deficient practice. The Director of Nursing Services or designee will audit on a biweekly basis times 4 and then randomly the schedule to identify residents who are at risk. What measures have been put in place or what systematic changes you will make to ensure that the deficient practice does not recur. All staff has been in-serviced on the importance of providing showers/baths and on the shower/bathing schedule. Audits will be completed the Director of Nursing Services or their designee on a bi-weekly basis times 4 and then randomly to identify any residents at risk. Audits will be completed by the Director of Nursing Services or their designee on a bi-weekly basis times 4 and then randomly to determine that documentation and Care Plans are present in the charts	

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F 312	Continued From page 6 provided. The CNA supervisor stated that the nurse's aides had been instructed to report to the nurse when a resident refused a bath and that the aide would indicate an "R" when the bath had been refused.	F 312	for those residents who refuse showers/baths. How the facility will monitor its corrective actions to ensure that deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change. The facility will monitor the effectiveness through the audits conducted by Medical Records for the Director of Nursing Services. These Audits will be reviewed by the Continuous Quality Assurance Committee at their Monthly Meeting. Compliance Date 4-30-09	
F 371 SS=B	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, the facility failed to ensure food was stored and prepared under sanitary conditions. Findings include: An inspection of the facility's kitchen and food service operations on 3/23/09 and 3/24/09 revealed the following: Outdated foods: In the kitchen's main refrigerator, there was a container of sour cream labeled with an open date of 3/22/09. The printed best-by date on the container was 3/16/09. There was also a block of moldy mozzarella cheese labeled with a discard date of 3/7/09. The Dietary Manger admitted that these food items should have been discarded.	F 371	**F-371 SANITARY CONDITIONS** What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice.	

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F 371	Continued From page 7 Misdated foods: In the main refrigerator, a block of cheddar cheese had an open date of 3/18/09 and a discard date of 8/18/09. There was also an opened container of sour cream with an open date of 3/22/09 and a discard date of 9/22/09. The dietary manager stated that the kitchen's policy was to discard leftovers after three days and to follow the corporation's "food labeling reference guide" for opened items. The reference guide indicated that cheese should have a discard date of two months after being opened. This practice conflicted with U.S. Food Code guidelines which indicate that all potentially hazardous foods should be discarded seven days after opening, or by the manufacturer's use-by date, whichever comes first. Sanitation: The can opener blade and the surfaces under the dish tables and entry hand sink were soiled. There was no evidence that the ice dispenser located in the dining room was being cleaned and sanitized on a regular basis. The Maintenance Director stated he thought the ice dispenser had not been cleaned for over a year. The manufacturer's instruction manual indicated that the ice dispenser was supposed to be cleaned at least twice a year.	F 371	The food items noted were discarded at the time they were discussed with Dietary Manager. How you will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. It is noted that no resident seemed to be adversely affected at the time the deficient practice was noticed. What measures have been put in place or what systematic changes you will make to ensure that the deficient practice does not recur. Dietary Staff have been in-serviced by the Dietary Manager on the Regulatory requirement for dating of food items. Staff has also been in-serviced on the proper disposal of items when the food item(s) fail to meet the Regulatory requirements. How the facility will monitor its corrective actions to ensure that	
F 431 SS=B	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		

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F 431	Continued From page 8 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and policy review the facility failed to label medications with the date they were opened, ensure safe and proper storing of drugs and biologicals, and to dispose of outdated medications. Findings include: Review of the facility's Storing Drugs policy and procedures identified the following: Drugs and biological will be stored in a safe, secure and orderly manner, at proper temperatures.	F 431	deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change. The Facilities Dietitians Consultant will monitor the facilities compliance of the Regulatory Requirements during her weekly visits and monthly inspection of the Dietary Department and report her findings to the Executive Director. These reports will also be monitored and reviewed by the Continuous Quality Improvement Committee at their monthly meeting. Compliance Date 4-30-09 **F 431 – PHARMACY SERVICES** What corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice. No residents were affected by the alleged deficient practice.	

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F 431	Continued From page 9 Review of the facility's Medication Expiration policy and procedure identified the following: "Date Opened" stickers would be used and that when a container was opened, the nurse opening the container was responsible for writing in the date opened on the sticker. On 3/24/09 at approximately 8:25 AM, an observation of the medication room was made. The following was found in the medication room refrigerator: One one vial of Pneumococcal vaccine was opened and not dated. One bottle of Xalatan eye drops was opened and not dated. The following was found in one of the drawers in the medication room: One bottle of Nitro Quick that had expired 12/08. Five vials of 10% Lidocaine that were opened and not dated. The following external products were stored next to internal (oral) products in one of the medication room cupboards: Three boxes of Fleets Enema with Mineral Oil. One box of Tylenol suppositories. One tube of Hemorrhoidal cream. Among other bottles of cough syrup stored in one of the upper cabinets in the medication room, one full bottle Geri Tussin DM cough syrup had a broken seal and was observed with some contents dried around seal and front of the bottle. In a bottom cupboard of the medication room, a	F 431	How you will identify other residents having the potential to be affected by the same deficient practice. The Director of Nursing Services or their designee will audit the Medication Room and Medication Carts for expired and or undated medications on a weekly basis x 4 and then randomly. All vials that were undated have been discarded. Resident with undated medications have been discarded and replaced. A divider has been installed in the medication cabinet in the medication room to separate the internal from the external medications. Sharps containers with disposed medications have been disposed of through our bio-hazard program. What measures have been put in place or what systematic changes you will make to ensure that the deficient practice does not recur.	

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F 431	Continued From page 10 sharps container was observed with numerous unidentifiable tablets, capsules and pills. At approximately 9:15 AM, the Director of Nurses was interviewed and acknowledged the medication room findings. On 3/24/09 at approximately 9:20 AM, an observation of the medication cart was made. The following were found: A bottle of prescription Robitussin cough syrup was opened an not dated. A house stock bottle Geri Tussin DM was opened an not dated. A house stock bottle of Glucosamine Sulfate was opened and not dated. A house stock bottle of Valerian Root was opened and not dated. One opened bottle of prescription Magic Mouthwash tabled "refrigerate." At approximately 9:35 AM, an licensed practical nurse was interviewed and acknowledged the medication cart findings.	F 431	Licensed staff has been in-serviced on the proper dating, storage and disposal of medications. Audits will be completed by the Director of Nursing Services or designee on a bi-weekly basis times 4 and then randomly to ensure that medications are stored, dated and disposed of properly. How the facility will monitor its corrective actions to ensure that deficient practice is being corrected and will not recur, i.e. what program will be put in place to monitor the continued effectiveness of the systemic change. The facility will monitor the effectiveness through the audits conducted by Medical Records for the Director of Nursing Services. These Audits will be reviewed by the Continuous Quality Assurance Committee at their Monthly Meeting. Compliance Date 4-30-09	